305 835 HEALTH CARE CLAIM PAYMENT/ADVICE

305.1 GENERAL INFORMATION

Introduction

This chapter contains information on processing electronic transactions based on the 004010X091 version of the ASC X12N Health Care Claim Payment/Advice (the HIPAA 835 transaction) Implementation Guide and the Addendum (004010X091A1) dated October 2002. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

Questions, comments, or suggestions regarding this information should be directed to hfswebmaster@illinois.gov Please identify submissions as being related to "Topic 305 of Chapter 300".

Paper Remittance Advice (RA) – DPA 194-M-1

For the immediate future, the Department will create both a paper RA and an electronic 835 for all claims adjudicated by the Department. The RA will contain the Department's proprietary rejection codes and messages instead of the reason and remarks codes used on the 835. The regular paper RA (194-M-1) will continue to report paid, rejected, and suspended claims. The Department will also continue to create a weekly RA which contains only rejected and suspended claims.

305.2 TECHNICAL INFORMATION

This section contains information related to reporting both paid and rejected claims data adjudicated by the Department. Additionally, this section will identify, down to the data element level, anything unique to the Department's processing of the 835 transaction.

Transmission Information

= The Department's Medical Electronic Data Interchange (MEDI) system is designed to communicate electronic RA (835) information. After obtaining the proper MEDI authorization, these electronic transactions can be retrieved by the Payee. Most, but not all, of these registrations will take place using the new MEDI/IEC system once that system becomes available. Certain payees, such as managed care organizations, the dental services contractor, and other State of Illinois agencies, will require a manual registration process; and they will be contacted individually prior to these systems becoming available.

Once payees are authorized by a provider and registered with the Department, the Department will create an electronic RA in the 835 format regardless of the method by which the claim was submitted. Authorized payees are those parties to whom the provider has authorized the Department to make claim payments. Consistent with Department policy, only authorized payees will have access to RA notices, regardless of the format. The Department can only create the electronic RA, in the 835 format, beginning with the date upon which the authorized payee registers with the Department. The Department will make the 835 available to authorized and registered payees for a maximum period of 60 calendar days from the date of posting to the MEDI/IEC web site.

As with the paper RA, the Department will create a weekly electronic version of the 835 that contains only rejected claims. Please review these carefully to determine if a claim can be corrected and resubmitted to the Department for payment consideration.

Note: The Department will **not** report suspended claims on the 835. Information regarding a suspended claim can be obtained by sending a Claim Status Request (276 transaction) to the Department.

When necessary, the Department may exceed the Implementation Guide's recommended limit of 10,000 CLP (claim) segments per ST-SE envelope.

Vouchers Under One Dollar

The Comptroller will not pay vouchers under a dollar. In order to report these vouchers while maintaining HIPAA compliance, HFS will use the PLB segment to reduce the payment (element BPR02) to zero. Element PLB04 will be the total for the current voucher that is under one dollar. A qualifier code of "J1" will be used in element PLB03 to indicate that the payment was reduced due to a limitation that prevents payment.

In order for the payees to determine the exact cause for the payment reduction, they will need to examine the claim detail for individual payment amounts. When the payee sees the voucher total is below one dollar, he/she should conclude this is why no payment was received.

Zero Dollar Vouchers

There will be cases where the payment amount for a voucher is zero. Since the Comptroller will not create a check for less than a dollar, the 835 will still be made available to the payee. There will not be a check number. The payment date in element BPR16 will be replaced with the adjudication date of the voucher.

Reporting Procedure Codes for Outpatient Institutional Claims

In order to tell the provider what code was used to reimburse the claim, all procedure codes or revenue codes will be reported in the 835, regardless of whether the codes were used in adjudication. The procedure code or revenue code used for adjudication will be reported in element SVC01.

Exception: Institutional Outpatient Medicare crossover claims will not be reported on a service line item basis on the 835, but will instead be reported on a "claim" basis.

Claim Adjustment

An adjustment must be reflected at either the claim level or the service level but cannot be reflected in both. There can be only one claim adjustment reason code per dollar amount. If a claim has more than one error, only one reason code will be reported on the 835.

Service Provider Name

This segment will be used only if the provider is different from the Payee. HFS will always complete this loop because the payee number is always different from the Billing Provider Number. In Loop 2100, NM102 (ID Code), the provider will always be coded as a non-person because HFS's provider database does not differentiate between person and non-person entities.

Corrected Priority Payer Name

This segment can only be used when HFS's Recipient file shows that another payer has priority for making a payment and the provider has not reported this payer in the 837. In Loop 2100, NM109, the ID Code will contain HFS's three-digit TPL code for that insurance company, followed by the group number.

Per Diem Reimbursement

The AMT segment will be used to report the per diem amount paid.

Disproportionate Share

The total amount reported on the 835 will include the disproportionate share amount.

Replacement And Void Of Prior Claim Transactions

Provider initiated voids will be processed on the next available voucher. A provider initiated replacement claim (void/rebill) will be vouchered on the same date as the void's matching rebill claim. This will mean that the void will be held in the MMIS system until the replacement claim is adjudicated (paid or rejected).

When a post adjudication adjustment is created by either HFS or the provider, the original claim or service section will be voided/reversed and then recreated with the adjusted amount on the 835.

Note: According to the 835 Implementation Guide, the reversal does **not** contain any **patient** responsibility amount in CLP or CAS segments.

= **Mass Adjustment**

A mass adjustment is used to adjust a paid claim when no detail is available on claims history, deposit a check received from a provider with no detail, recover an amount owed to the Department due to an audit or possibly an open aged adjustment. There are several adjustment process types that are considered mass adjustments such as 09D, 32C, 15C, and 06C.

= **Mass-to-Detail (M-T-D) Adjustment**

A calculated net adjustment comprised of one or more lines of detail adjustments processed by recipient and date of service. The net adjustment (mass) of the detail lines is posted as a credit or debit and paid or recovered on the remittance advice and can be identified as an "alien recipient". A report is mailed separately to provider, which provides the detail of the mass adjustment. The mass adjustment can be matched with the detail by using the document control number (DCN) on the remittance advice and detail report.

=305.3 REMITTANCE ADVICE TRANSACTION SET AND TOTAL PAYMENT AMOUNT

When the payment amount in element BPR02 is 0 the following elements will be set as follows:
BPR01 = ‘H’
BPR04 = ‘NON’
N102 in loop 1000A (payer name) will be "ILLINOIS MEDICAID" .
N301 in loop 1000A (payer street address) will be "201 SOUTH GRAND AVENUE EAST"
N401 in loop 1000A (Payer city) will be "SPRINGFIELD"
N402 in loop 1000A (Payer state) will ‘IL’
N403 in loop 1000A (Payer ZIP) will be ‘62763’

When the payment amount in element BPR02 is greater than or equal to $1 the following elements will be set as follows:
BPR01 = ‘I’
BPR04 = ‘CHK’ or ‘ACH’
N102 in loop 1000A (payer name) will be "ILLINOIS COMPTROLLER" .
N301 in loop 1000A (payer street address) will be "325 W. ADAMS ST"
N401 in loop 1000A (Payer city) will be ‘SPRINGFIELD’
N402 in loop 1000A (Payer state) will ‘IL’

N403 in loop 1000A (Payer ZIP) will be '627041871'

305.4 OVERPAYMENT RECOVERY

The Department's claims processing system will recognize that money is owed to the Department by a payee in several situations. One of these situations is when a previously paid claim is voided or is reduced as a result of a post-payment adjustment. Another situation, not related to specific claims, is when a review or a financial recovery instance results in the payee owing money to the Department.

In each situation, when it is recognized that the payee owes money to the Department, the amount of the credit due is posted to the Department's accounting system. However, the credit may or may not be recouped or 'applied' within the same 835 transaction. A PLB segment containing the overpayment recovery ("WO") qualifier in PLB03-1, with the negative dollar amount of the credit posted will be provided within the 835 to show that the credit is due but not yet recouped. When a recovery is made to satisfy this credit (either within the same 835 or a later 835) another PLB segment will be provided containing the dollar amount of the recovery (application of credit) expressed as a positive value and containing the overpayment recovery ("WO") qualifier in PLB03-1.

These two types of PLB segments will be provided in addition to the CLP segments (for detail claim voids or adjustments) and the PLB segments (for provider level adjustments) that caused the credit to be owed to the Department initially. These PLB segments serve to allow the 835 to balance to the amount paid. They also allow the payee to be notified of each instance of a credit amount due the Department and each application or recovery of a credit, even when the application does not fully recover the entire amount owed to the Department. Three items of information will be included in the PLB03-2 element to enable the PLB segment to be associated with the original claim or provider level adjustment:

1. HFS Process Type code
2. Recipient Identification Number
3. Document Control Number (DCN) of the original claim or of the provider level adjustment.

The Department will not use the "forwarding balance" method, as allowed by the 835 Implementation Guide, to denote the amount owed by the Payee.

Example of a Voided Claim

When a claim is voided, it will be reported in the 835 by using a CLP segment with a status code of 22. This CLP reversal will reduce the total payment amount represented in element BPR02. Since the amount owed to the Department as a result of voiding the previously paid claim may not be recovered within this 835, it is necessary to offset this amount to cause the payment in BPR02 to match the amount actually paid by the check associated with this 835. This is done by issuing

a PLB segment with an adjustment qualifier of WO and a negative amount equaling the net effect of the reversal CLP segment.

RA on which the claim is voided:
CLP*1234*22*-100*-100***orig DCN 1~*
= REF*F8**DCN of previous adjustment~*
PLB*prov num*20031231*WO:*PRCS type recip ID orig DCN 1*-100~*

A later RA on which the money owed is recovered:
PLB*prov num*20031231*WO:*PRCS type recip ID orig DCN 1**100~

Example of Voided Claim with Returned Check

When a claim is voided by the Payee remitting to the Department the amount of the net payment for the claim, the RA will show that the claim amount is reversed by a CLP segment. A PLB segment will also be present to offset the reversed claim payment so that the overall payment in BPR02 is not reduced. The PLB segment will contain an adjustment reason code qualifier of 'CS' to signify that the amount due the Department has already been paid and no recovery from future payments is needed.

RA on which the voided claim with returned check is shown:
CLP*1234*22*-100*-100***orig DCN 1~*
= REF*F8**DCN of previous adjustment~*
PLB*prov num*20031231*CS or B2:*PRCS type recip ID orig DCN 1*-100~*

Example of a Re-billed Claim (Bill Frequency 7)

RA on which the original claim is reversed and replaced:
CLP*1234*22*-100*-100***orig DCN 1~*
= REF*F8**DCN of previous adjustment~*
CLP*1234*1*100*90***new DCN 2~*
REF*F8**orig DCN 1~*
PLB*prov num*20031231*WO:*PRCS type recip ID orig DCN 1*-100~*

In this case, claim DCN 1 originally paid at $100 is being reversed. A new claim has been adjudicated at the new payment amount of $90. The PLB prevents the total payment of the voucher from being reduced and informs the payee that the money owed is not being recovered at this point.

RA on which the money owed is recovered:
PLB*prov num*20031231*WO:*PRCS type recip ID orig DCN 1**100~

= **The REF segment in loop 2100**

Use of this segment is only for Long Term Care (LTC) claims and adjustments. The REF segment may be used in reversal CLP segments. This segment will carry the DCN of the previous adjustment if this claim has been adjusted prior to the current

adjustment. If the current adjustment is the first adjustment then the REF segment will not be used. Element REF01 will have the qualifier F8 and element REF02 will have the DCN. This will allow the department to create a history chain from the most recent adjustment to the original claim.

This will include DCNs of the detail portions of MASS-to-DETAIL adjustments. The MASS-to-DETAIL adjustments are not sent in the 835 using the CLP reversal and correction process. MASS-to-DETAIL adjustments are reported in the PLB using the DCN of the mass portion of the MASS-to-DETAIL. In order to maintain the history chain in the reversal and correction process, the REF segment in the reversal CLP may refer to the DCN of a detail portion of a MASS-to-DETAIL adjustment. If the REF segment refers to a MASS-to-DETAIL DCN then the provider will not find that DCN in a CLP segment of a previous claim.

There will always be a REF segment in the correction CLP of all adjustments that create correction CLP segments. This REF segment will refer back to element CLP07 of the associated reversal segment, not the REF segment of the reversal CLP segment. Element REF01 will have the qualifier F8 and element REF02 will have the DCN.

305.5 PATIENT NAME (NM1) SEGMENT

The patient name is a required segment in the 835, however the patient name may not be available when processing a claim that was submitted prior to the implementation of HIPAA. Even prior to HIPAA, HFS would reject a claim submitted without the recipient name or number; however, it is possible that HFS may have to reprocess pre-HIPAA claim data through the adjudication system.

When the 835 system encounters a rejected claim that has no recipient data then HFS will return “not received” in elements NM103 (last name) and NM104 (first name). If the recipient number is missing, HFS will return ‘000000000’ in element NM109 (identification code).

EDI Information

The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the 835 transaction. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
46	Header	Financial Information	BPR02	Monetary Amount	Will represent the full payment amount for the Payee.
=46	Header	Financial Information	BPR04	Payment Method Code	Refer to Section 305.3.
=49	Header	FEIN	BPR10	Originating Company Identifier	If payment balance is zero, this will be “1371320188”. If payment is issued, this will be “1376002057 “
53	Header	Reassociation Trace Number	TRN02	Reference Identification	Will represent the Check/Warrant Number appended to the Voucher Number.
61	Header	Production Date	DTM02	Date	Will represent Schedule Date (from Julian date in Voucher Number).
=63	1000A	Payer Identification	N102	Name	If payment balance is zero, this will be “ILLINOIS MEDICAID”. If payment is issued, this will be ‘ILLINOIS COMPTROLLER’.
72	1000B	Payee Identification	N103	Identification Code Qualifier	Will be “FI”.
=74	1000B	Payee Identification	N301	Address Information	If payment balance is zero, this will be "201 SOUTH GRAND AVENUE EAST". If payment is issued, this will be "325 W. ADAMS ST".
=75	1000B	Payee Identification	N401	City Name	Will be "SPRINGFIELD".
=75	1000B	Payee Identification	N402	State or Province Code	Will be “IL”.
=76	1000B	Payee Identification	N403	Postal Code	If payment balance is zero, this will be "62763". If payment is issued, this will be "627041871".

IG Page #	Loop	Description	Element ID	Element Name	Remarks
80	2000	Provider Summary Information	TS302	Facility Code Value	For Professional Claims (837P), HFS will report Code 11 (Office) as the place of service, if the 837P contains more than one value.
=81	2000	Provider Summary Information	TS302	Facility Code Value	For Institutional Claims (837I), HFS will report the first 2-bytes of the bill type code. For Professional Claims (837P) and Long Term Care Claims, the code will be 11 (Office). For Pharmaceutical Claims, the code will be "99" (Other).
90	2100	Claim Payment Information	CLP02	Claim Status Code	Will be "1", "2", "3", "4", or "22".
91	2100	Claim Payment Information	CLP03	Monetary Amount	Will be the total billed amount.
91	2100	Claim Payment Information	CLP04	Monetary Amount	Will be the total paid amount.
92	2100	Claim Payment Information	CLP06	Claim Filing Indicator Code	Will be "MC".
93	2100	Claim Payment Information	CLP07	Reference Identification	Will be the Document Control Number (DCN).
93	2100	Claim Payment Information	CLP08	Facility Code Value	This is the 1st 2-bytes of the Bill Type Code.
96	2100	Claim Adjustment	CAS01	Claim Adjustment Group Code	Will be "PR", "CO", or "OA".
103	2100	Patient Name	NM103	Name Last or Organization Name	Will be Recipient's Last Name.
103	2100	Patient Name	NM104	Name First	Will be Recipient's First Name
103	2100	Patient Name	NM108	Identification Code Qualifier	Will be "MR".

IG Page #	Loop	Description	Element ID	Element Name	Remarks
109	2100	Corrected Patient/Insured Name	NM102	Entity Type Qualifier	If used, will be “1”.
109	2100	Corrected Patient/Insured Name	NM103	Name Last or Organization Name	If used, will be Recipient’s Last Name.
109	2100	Corrected Patient/Insured Name	NM104	Name First	If used, will be Recipient’s First Name.
109	2100	Service Provider Name	NM103	Name Last or Organization Name	Will be the Provider Name as it appears on the Provider Information Sheet.
109	2100	Service Provider Name	NM108	Identification Code Qualifier	Will be “MC” or “FI”.
131	2100	Claim Date	DTM01	Claim/Date Qualifier	Will be “232”, or “233”.
135	2100	Claim Supplemental Information	AMT01	Amount Qualifier Code	Will be “DY” for per diem Amount. Will be “F5” for Patient Amount.
137	2100	Claim Supplemental Information Quantity	QTY01	Quantity Qualifier	Will be “CA”, or “NA”.
142	2110	Service Payment Information	SVC02	Monetary Amount	Will be the billed amount.
142	2110	Service Payment Information	SVC03	Monetary Amount	Will be the payment amount.
165		Provider Adjustment	PLB01	Reference Identification	Will be the Provider ID Number, Payee ID Number.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
170		Provider Adjustment	PLB03-02	Reference Identification	Will be the HFS Process Type Code, the Recipient Identification Number and the Document Control Number (DCN).